

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-030551

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 116 Primary Registration District No. 4187 Registrar's No. 1811. ~~FILED~~ **FILED** **SEP 4 1962**
a. COUNTY **FRANKLIN**b. CITY (If outside corporate limits, give TOWNSHIP only)
OR TOWN **UNION**

Length of stay in 1b

c. CITY
OR TOWN **UNION**Inside Limits
Yes ☒ No ☐c. FULL NAME OF (If NOT in hospital, give location)
HOSPITAL OR INSTITUTION **AT HOME**Inside Limits
Yes ☐ No ☐d. STREET ADDRESS (If outside, give location)
407 E. State St.Reside on Farm
Yes ☐ No ☒3. NAME OF DECEASED
(Type or print)First
DAVIDMiddle
W.Last
BREID4. DATE
OF DEATHMonth
AUGUSTDay
23,Year
19625. SEX
MALE6. COLOR OR RACE
WHITE7. Married ☒ Never Married ☐
Widowed ☐ Divorced ☐8. DATE OF BIRTH
FEB. 1, 18739. AGE (last birthday)
89IF UNDER 1 YEAR IF UNDER 24 HR
Months **6** Days **22** Hours Min. 10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)10b. KIND OF BUSINESS OR INDUSTRY
LAWYER11. BIRTHPLACE (City and state or country)
MOCANE, MO.12. CITIZEN OF WHAT COUNTRY
U.S.A.

13a. FATHER'S NAME

JACOB BREID

13b. MOTHER'S MAIDEN NAME

SUSAN KLEEK

14. NAME OF HUSBAND OR WIFE

MAYTIE R. BREID15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes, give war or dates of service)
NO

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

MRS. MAYTIE R. BREID 407 E. STATE18. CAUSE OF DEATH (Enter only one cause per line)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Thrombotic cerebrovascular**UNION, MO.**INTERVAL BETWEEN
ONSET AND DEATHConditions, if any,
which gave rise to
above cause (a),
stating the under-
lying cause last.

DUE TO (b)

Dissecting

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal
disease condition given in PART I (a)
Renalized thrombotic cause Under.PART III. If deceased was female was
there a pregnancy in last 90 days.☐ Yes ☒ No ☐ Unknown19. WAS AUTOPSY
PERFORMED?
YES ☐ NO ☒20. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF
INJURYHour
a.m.
p.m.20d. INJURY OCCURRED
WHILE AT WORK ☐
NOT WHILE AT WORK ☐20e. PLACE OF INJURY (e.g., in or about home,
farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION

COUNTY

STATE

21. I attended the deceased from **1960****6:45 a.m.**to **8/23/62** and last saw her
him alive on **8/23/62**Death occurred at **6:45 a.m.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE

(Degree or title)

22b. ADDRESS

22c. DATE SIGNED

23a. BURIAL, CREMATION,
REMOVAL (Specify)

23b. DATE

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION (City, town, or county)

(State)

BURIAL**AUG. 25, 1962****MIDLAWN MEM. GARDENS****UNION,****MO.**

24. FUNERAL DIRECTOR

ADDRESS

25. DATE REC'D BY LOCAL REG.

26. REGISTRAR'S SIGNATURE

OLTMANN FUNERAL HOME**UNION, MO.****8/29/62****Lula C. Hudman**

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. SHOULD READ

INSTEAD OF

DATE AMENDED

BY AFFIDAVIT OF

DOCUMENT

MEDICAL CERTIFICATION

VS 300
Rev. 4/59**10364****203642****3****4 0****5 1****6****7 0****8 2****9422.1****10****11****1290-0****135-0**

SEP 5 1962

OCT 16 1962

JAN 15 1963

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Ralph Ottmann

Licensed Embalmer No. 4808

P. O. Address Union, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.